Health Action Plan Instructions

The Health Action Plan (HAP) is a tool to document goals that the member will pursue within the Health Home. The HAP also documents the proposed process for achieving these goals, as well as progress made in achieving the goals. The HAP is developed by the member and Care Manager or Coordinator with input from others who are participating in the Health Home, and anyone else the member chooses to include in the process. A comprehensive assessment is completed prior to or during the development of the HAP. The HAP is developed in a face-to-face meeting with the member, and any other members of the Health Home team available to participate.

HAPs should be updated at minimum every 90 days in a face to face setting with at least the Care Coordinator and the member being the goal.

Drop down boxes are provided for some information, while other information must be typed in. Not all information requested will apply to each member. When information does not apply, type in N/A. All applicable areas of the HAP must be completed in full; whether completed in an electronic health record or on the form posted on the state's website.

Section I

Complete all areas of the demographic information for the member.

Section II

Complete all lines for each contact as applicable. If not applicable, type in N/A.

Section III

Provider: Complete all lines for each provider selected

Kan Be Healthy Screen: Is the child up to date on his/her age related health screenings? If yes, what was the date of the last screening?

Health Risk Assessment: Did you complete a holistic assessment or utilize other provider data to answer your assessment questions? What is the date you completed your assessment?

Common Valid Assessments:

a. ComCAM 13 – Caregiver Activation Measure

b. PAM – Patient Activation Measure

c. History and Physical

d. FACT – Health Home survey assessment

e. GAD7 – General Anxiety Disorder Scale

f. PHQ-9 – Depression Patient Health Questions

g. CAGE Alcohol Detection Questionnaire

h. DAST-10 – Drug Abuse Screening Test

i. Fall Free Plan

j. FLACC Pain Assessment

k. Katz Index of Independence in Activities of Daily Living

l. Wong-Baker Faces

Physical Health:

Physical Health Diagnoses: utilize the MCO portal, other provider information, assessment findings, your clinical systems to list all of the associated physical health diagnoses.

Height: Enter the height in feet/inches or inches (5' 4" or 64")

Weight: Enter the weight in pounds (150 lbs or 150.5 lbs)

Cardio:

BP: Enter the blood pressure with a systolic and diastolic result (140/90)

Diabetes: Members with a confirmed diagnosis of diabetes only. Enter Pending if test is in progress or requested.

A1c: Enter the result as indicated by lab results

LDL-c: Enter the results as indicated by lab results

Obesity:

BMI: Utilize a BMI chart or use BMI calculator tool

(http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm)

Tobacco Use: If member uses tobacco, please provide a description of the current use.

Behavioral Health:

Mental Health Diagnoses: utilize the MCO portal, other provider information, assessment

findings, your clinical systems to list all of the associated behavioral health diagnoses.

Depression Screening performed: This may be performed by the HHP using the PHQ9 or other valid tool, or by another provider. Provide the date the screening was performed.

Substance Use Disorder Brief Screen: This may be performed by the HHP using the short form SBIRT, Audit-C or other valid tool, or by another provider. Provide the date the screening was performed.

Substance Use Disorder Assessment: This may completed by HHPs or by another provider.

Medication Reconciliation: The process of identifying the most accurate list of all medications that the patient is taking (over the counter and prescribed), including name, dosage, frequency, and route, by comparing the medical record or provider Medication Administration Record (MAR) to an external list of medications obtained from a patient, hospital, MCO portal, or other provider. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions. ***Reconciliation should be done at every transition of care in which new medications are ordered or existing orders are rewritten.*** Transitions in care include changes in setting, service, practitioner, or level of care. This process comprises five steps: (1) develop a list of current medications; (2) develop a list of medications to be prescribed; (3) compare the medications on the two lists; (4) make clinical decisions based on the comparison; and (5) communicate the new list to appropriate caregivers and to the patient. Each medication is to be listed on the HAP. Do not insert "see MAR".

Section IV

Indicate whether the member has a Home and Community Based Services waiver plan in place, and the type of waiver plan. It is important to understand all of the medical and waiver benefits available to the member so as to ensure appropriate utilization and management of services.

Section V

Indicate whether the member has an Advanced Directive. Provide education for members who may not understand the concept of an Advanced Directive. ,

Section VI

. Members may have as few as one Health Home goal or they may have several. Health Home goals should be member driven and relate to some aspect of their health and well being. Gaps in

health care access, service delivery or self-care management skills are preferred. Written goals should follow the SMART principle:

S= Specific, what exactly will be done

M= measurable, how will you know the goal has been achieved?

A= achievable, is the goal written in a way that makes sense and appropriate for that particular person

R= realistic, is it too hard, too long of a time frame, or maybe too easy?

T= timely, is the deadline/timeframe appropriate for the goal and the member?

http://keltymentalhealth.ca/healthy-livingits-everyone/tools-resources/my-healthy-living-pinwheel

Goal: The goal line contains the entire SMART goal. Example of a SMART goal: Earleen will choose one Primary Care Physician (PCP) to oversee her medical care and make an appointment to have a diabetes check by March 31, 2015.

- **Steps to Achieve Goal:** Address the steps that will be taken to achieve the goal, including who is responsible to assist the member in achieving the goal and where services will be provided.
    - Earleen's Care Coordinator will
        - assist her to choose a PCP and schedule her first appointment
        - assist her in setting up transportation
        - prepare a list of questions
        - attend the first appointment with Earleen to help her explain her medical issues, her participation in a Medicaid Health Home, and help her to understand the information provided by the PCP
        - educate Earleen regarding how to set up transportation through her MCO for future appointments with her PCP
        - help Earleen fill medications and complete any ordered tests
- **Strengths and Needs:** This section should address any strengths that may help the participant to achieve the goal, or needs that may prove a barrier to achieving the goal. Consideration should be given to such areas as family or community support, communication, education, socio-economic status, housing, transportation, etc.
    - Earleen has a sister with whom she currently lives, however she is unable to provide much support in terms of Earleen's physical or behavioral care, including transporting her to and from appointments. Earleen will need transportation, and will need someone to go with her to her initial visit, at a minimum.

- **Measureable Outcome(s):** This section should state how it will be determined that this goal was met.
- The Care Coordinator will contact Earleen once weekly to provide support in achieving this goal **Start Date:** Indicate the date the goal is established.
- **Completion Date:** Indicate the date the goal was met.
- **Progress:** Document any progress toward achieving the goal.
    - Earleen selected a PCP from a list provided by her Care Coordinator. With the assistance of her Care Coordinator, she scheduled her first appointment for 4/1/2015 at 1:30 PM. Her Care Coordinator will meet her at her initial appointment.

Section VII

Section VII includes the hand written signature of the participant, as well as the signatures of those who participated in developing the HAP and their relationship to the participant. The physician does not need to sign the HAP unless involved in the development of the plan. Copies of the HAP should be given to the participant, the PCP, those who participated in developing the HAP, as well as anyone else involved in achieving the goal(s) established in the HAP within 30 days of completion. This sharing of information helps to ensure all providers in the member's care network are aware of the member's participation in Health Homes and are able to review the care summary and advise of any discrepancies or concerns.